Synchronous Metastatic Rectal Cancer Case Discussion

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Male, 68 ys

Rectal bleeding, non-obstructive symptoms

Comorbidities: morbid obesity (BMI= 32), hypertension

No family history for colorectal cancer

Physical examination: DRE - rectal tumor @ 6cm from anal verge
Case Discussion
Synchronous Rectal CA/Metastatic Disease

**Colonoscopy:** ulcerated lesion, 6cm from the anal verge

Pathology: Grade II Adenocarcinoma

CEA: 10ng/dl (normal reference: 5.0)

K-ras: wild-type

MSS
Extraperitoneal Rectal Cancer

Peritoneal reflection

Primary
Threatened CRM (by EMVI+)
Threatened CRM (by EMVI+)
Extra-mesorectal node - Lateral pelvic node (8mm)
Threatened CRM (by EMVI+)
Liver MR & Diffusion-weighted sequences
8 lesions in total
Treatment options?

1. Surgery (Primary first)
2. Surgery (liver first)
3. RT first (Long-course CRT)
4. RT (Short-course followed by chemo)
5. Chemotherapy alone first
Case Discussion
Synchronous Rectal CA/Metastatic Disease

RT short-course

1. Regular 5x5Gy
2. Boost to Primary
3. Boost to Primary and Lat pelvic node
Following short-course, what chemotherapy regimen?

MSS
K-ras wild-type

1. FOLFOX, Bevacizumab
2. FOLFIRI, Bevacizumab
3. FOLFOX, Cetuximab/ Panitumumab
4. FOLFIRI, Cetuximab/ Panitumumab
5. FOLFOXIRI with Bevacizumab
6. FOLFOX
7. FOLFIRI
Folfoxiri + Bevazicumab

2 cycles

Severe anal pain
Severe mucositis
Folfoxiri + Bevazicumab

2 cycles

Severe anal pain
Severe mucositis

MR
Folfoxiri + Bevazicumab

2 cycles

Severe anal pain
Severe mucositis

Epidural
Exam under anesthesia
Infected Deep Anorectal Fissure
Exam under anesthesia

- **Normal Mucosa**
- **Infected Deep Anorectal Fissure**
Epidural for pain control
Now what?

1. Re-stage & consider surgery (now)
2. Re-stage & consider surgery (wait 6 weeks/Bev)
3. More chemo (same)
4. More chemo (change - remove Bev)
CRM NOT threatened...
Best management here is?

1. Surgery of the primary + LPLND + anastomosis
2. Surgery of the primary + LPLND + NO anastomosis
3. Surgery of the primary + anastomosis (no LPLND)
4. Surgery of the primary + NO anastomosis (no LPLND)
5. Diverting colostomy
6 weeks after last dose Bevazicumab
Laparoscopic LAP with taTME
Left lateral pelvic node dissection
Laparoscopic LAR with TaTME
Left lateral node dissection
No anastomosis
Laparoscopic Rectosigmoidectomy with TaTME
Left lateral node dissection
Laparoscopic Rectosigmoidectomy with TaTME
Left lateral node dissection
<table>
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<tr>
<th>Pathology Report</th>
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| **Tumor location** | Rectum  
| **Tumor size** | 7cm  
| **Histological type** | Grade II adenocarcinoma  
| **Histologic grade** | Moderately differentiated  
| **Tumor extension** | >5mm Mesorectum (ypT3c)  
| **Proximal Margin** | Free  
| **Distal margin** | Free  
| **Radial Margin** | 10mm  
| **Lymphatic invasion** | Present  
| **Vascular invasion** | Present  
| **Perineural invasion** | Present  
| **Lymph nodes** | Metastasis to 8/55 lymph nodes  
| **Lateral nodes** | 0/18  

 ypT3 N2b - TRG 2
Pre-op (Primary)

3 mo. post-op (Primary)

hemangioma

hemangioma
Discharged (20d post-op)

Then what?

1. More chemo
2. Liver resection
Case Discussion
Synchronous Rectal CA/Metastatic Disease

Poll #7

What chemo?

1. FOLFOX, Bevacizumab
2. FOLFIRI, Bevacizumab
3. FOLFOX, Cetuximab/ Panitumumab
4. FOLFIRI, Cetuximab/ Panitumumab
5. FOLFOXIRI with Bevacizumab
6. FOLFOX
7. FOLFIRI
What chemo?

1. FOLFOX, Bevacizumab
2. FOLFIRI, Bevacizumab
3. **FOLFOX, Cetuximab**
4. FOLFIRI, Cetuximab/ Panitumumab
5. FOLFOXIRI with Bevacizumab
6. FOLFOX
7. FOLFIRI
Pre-op

3mo. post-op

6mo. post-op

hemangioma

hemangioma

hemangioma
Next step?

1. Liver Resection (only of currently seen nodules)
2. Liver Resection (based on pre-treatment nodules)
3. Liver Transplantation
4. Continue chemotherapy
Thank You
Synchronous liver Metastases in Patients with Rectal Cancer

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Disclosure

• Advisory Boards:
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Case 1

• Mr. EH is a 55 year old male patient

• PMH: None
• PSH: None
• Social history: Chronic heavy smoker (80py), moderate alcohol intake
• Family history: negative for malignancy

• CC: blood per rectum, constipation and weight loss of 5 kg in 2 months
Case (Cont’d)

• Colonscopy (6/20/2017): Nearly obstructing circumferential friable rectal mass at 5cm from the anal verge.

• Pathology showed infiltrating moderately differentiated adenocarcinoma, RAS/BRAF wild type, MSS

CEA: 44 ng/mL
1. Circumferential thickening of the rectal mucosa causing severe narrowing and secondary bowel dilatation and fecal retention.
2. Large metastatic liver lesion **measuring 9 X 4 cm**
3. Multiple tiny retroperitoneal, sacral and iliac lymph nodes
Approach to patient with rectal cancer and synchronous liver metastases

- Surgery (rectum and liver)
- Surgery (rectum and liver) followed by systemic chemotherapy
- Systemic chemotherapy followed by surgery (rectum and liver)
- Systemic chemotherapy, SCRT followed by surgery (rectum and liver)
- Systemic chemotherapy
PET CT Scan

Severe abdominal pain with obstructive symptoms
Laparoscopic loop sigmoid colostomy
What type of chemotherapy in RAS wild type?

- FOLFOX, Bevacizumab
- FOLFIRI, Bevacizumab
- FOLFOX, Cetuximab/Panitumumab
- FOLFIRI, Cetuximab/Panitumumab
- FOLFOXIRI with Bevacizumab
- FOLFOX
- FOLFIRI
Case (Cont’d)

• 6 cycles of FOFOX and panitumumab
Diagnosis

After 6 cycles of FOLFOX and Panitumumab

- Decrease in the rectal circumferential thickening.
- Decrease in the large metastatic liver lesion involving segment VIII, VII, V and VI measuring now 2.7 x 4.2 cm

Response to treatment
PET CT Scan

Diagnosis

After 6 cycles of FOLFOX and Panitumumab

Response to treatment
1. Solitary liver metastasis in segment V/VIII. The portal vein and hepatic veins are patent.

2. Two small simple hepatic cysts
Patient had good response to chemotherapy. What’s next?

• Continue on the same treatment
• Maintenance chemotherapy with 5-FU and Bevacizumab or Panitumumab
• Liver resection followed by SCRT and surgery
• Liver resection followed by rectal surgery
• Rectal surgery followed by liver resection
• Rectal and liver surgery in the same setting followed by chemotherapy
• Chemoradiation followed by surgery for both sites
Case (Cont’d)

• 11/2017: Resection of segment V, and part of segment VI and VII.

• Pathology: liver, trisegmentectomy:
  Positive for adenocarcinoma, consistent with metastasis. Surgical margins, free of tumor with treatment effect
Case (Cont’d)

1/2018: short course of radiotherapy (25 Gy in 5 fractions)

Plan was to proceed with rectal surgery 6-8 weeks after XRT .......................... BUT......
CT Chest Abdomen and Pelvis 3/2018

Increase in the size of retroperitoneal lymph nodes

Multiple bilateral lung nodules

Disease progression
Case (Cont’d)

6 cycles of FOLFIRI, Cetuximab
1. Unchanged primary rectal tumor.
2. Decreased retroperitoneal lymphadenopathy.
3. Significant interval decrease in size of all the lung nodules.

Response to treatment
Case (Cont’d)

6 more cycles of FOLFIRI, Cetuximab (Total 12 cycles)
1. Unchanged primary rectal tumor.
2. No new or progressive metastatic disease in the abdomen or pelvis.
3. Post therapy changes in the pelvis with bladder wall and presacral soft tissue thickening.

1. Stable pulmonary nodules.
2. No new pathology in the chest.
What’s Next?

• Surgery (APR) and RFA of lung lesion
• Biopsy and RFA of lung lesion
• Continue on the same treatment
• Switch to maintenance therapy and re-evaluate in 3 months
• Observation
PETCT 11/2018

1. Stable disease in the abdomen and pelvis
2. FDG-avid right upper lung nodule,

• CT-guided biopsy and ablation of the right upper lung lesion
• Pathology: Right lung, core biopsy: metastatic adenocarcinoma consistent with colorectal origin

• Continue 5 Fu- Bevacizumab
1. Unchanged primary rectal tumor
2. Stable bilateral lung nodules (non-specific)
3. Unchanged subcentimetric retroperitoneal lymph nodes

What’s Next?
Surgery?
More Chemotherapy?
Observation?
THANK YOU